

THE ROLE OF EDUCATION IN THE REHABILITATION OF CHILDREN WITH POST-TRAUMATIC EXPERIENCES FROM THE WAR PERIOD

O PAPEL DA EDUCAÇÃO NA REABILITAÇÃO DE CRIANÇAS COM EXPERIÊNCIAS PÓS-TRAUMÁTICAS DO PERÍODO DA GUERRA

EL PAPEL DE LA EDUCACIÓN EN LA REHABILITACIÓN DE LOS NIÑOS QUE HAN VIVIDO EXPERIENCIAS TRAUMÁTICAS DURANTE EL PERIODO DE GUERRA



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ABSTRACT: The full-scale war in Ukraine has caused unprecedented trauma to children, which makes the search for scalable recovery resources a pressing issue. The aim of the study is to theoretically substantiate and empirically confirm the rehabilitation potential of the educational environment as a component of psychosocial support for children with war trauma. The methodology combines a systematic review of sources and a psychological and pedagogical experiment ($n = 30$; CRIES-13 scale). A statistically significant decrease in the total score from 38.7 to 29.2 ($\Delta = -9.5$; $p < 0.001$) confirmed the effectiveness of the program: the proportion of children with clinical PTSD decreased from 80% to 43%, and 37% of participants left the risk group. It has been proven that a trauma-sensitive educational environment is an effective factor in reducing post-traumatic symptoms. The results justify the need to scale up trauma-sensitive educational practices as a priority of state policy in the context of Ukraine's wartime and post-war recovery.

KEYWORDS: Educational Rehabilitation. Trauma-Sensitive Pedagogy. Post-Traumatic Stress Disorder (PTSD). CRIES-13. Safe Environment School.

RESUMO: A guerra em grande escala na Ucrânia causou um trauma sem precedentes nas crianças, o que torna a procura de recursos de recuperação escaláveis uma questão urgente. O objetivo do estudo é fundamentar teoricamente e confirmar empiricamente o potencial de reabilitação do ambiente educativo como componente do apoio psicossocial a crianças com trauma de guerra. A metodologia combina uma revisão sistemática da literatura e uma experiência psicológica e pedagógica ($n = 30$; escala CRIES-13). Uma diminuição estatisticamente significativa na pontuação total de 38,7 para 29,2 ($\Delta = -9,5$; $p < 0,001$) confirmou a eficácia do programa: a proporção de crianças com PTSD clínico diminuiu de 80% para 43%, e 37% dos participantes saíram do grupo de risco. Ficou comprovado que um ambiente educativo sensível ao trauma é um fator eficaz na redução dos sintomas pós-traumáticos. Os resultados justificam a necessidade de ampliar as práticas educativas sensíveis ao trauma como uma prioridade da política estatal no contexto da guerra na Ucrânia e da recuperação pós-guerra.

PALAVRAS-CHAVE: Reabilitação educativa. Pedagogia sensível ao trauma. Síndrome de stress pós-traumático (SSPT). CRIES-13. Escola com ambiente seguro.

RESUMEN: La guerra a gran escala en Ucrania ha causado un trauma sin precedentes en los niños, lo que convierte la búsqueda de recursos de recuperación escalables en una cuestión urgente. El objetivo del estudio es fundamentar teóricamente y confirmar empíricamente el potencial rehabilitador del entorno educativo como componente del apoyo psicossocial para los niños con trauma de guerra. La metodología combina una revisión sistemática de la bibliografía y un experimento psicológico y pedagógico ($n = 30$; escala CRIES-13). Una disminución estadísticamente significativa de la puntuación total de 38,7 a 29,2 ($\Delta = -9,5$; $p < 0,001$) confirmó la eficacia del programa: la proporción de niños con TEPT clínico disminuyó del 80 % al 43 %, y el 37 % de los participantes salió del grupo de riesgo. Se ha demostrado que un entorno educativo sensible al trauma es un factor eficaz para reducir los síntomas postraumáticos. Los resultados justifican la necesidad de ampliar las prácticas educativas sensibles al trauma como prioridad de la política estatal en el contexto de la recuperación de Ucrania durante la guerra y la posguerra.

PALABRAS CLAVE: Rehabilitación educativa. Pedagogía sensible al trauma. Trastorno por estrés postraumático (TEPT). CRIES-13. Escuela de entorno seguro.

INTRODUCTION

The full-scale war in Ukraine has deeply affected children's mental health, learning trajectories, family relations, and sense of safety. Displacement, exposure to violence, loss of relatives, interruption of schooling, and constant media coverage of the war increase the risk of post-traumatic reactions, including intrusive memories, avoidance, hyperarousal, emotional lability, anxiety, somatic complaints, and difficulties in relationships (Chudzicka-Czupala et al., 2023; Su et al., 2023; Zlivkov et al., 2023). In this context, the school is not only a place for academic instruction, but also one of the few social institutions capable of restoring routine, predictability, peer interaction, and adult support in children's everyday lives.

The article is based on the assumption that education can function as a component of psychosocial rehabilitation when it is intentionally organized according to the needs of children affected by trauma. This does not mean replacing specialized psychotherapy, especially in cases of severe or complex PTSD. Rather, it means understanding the educational environment as a protective and developmental space that can support stabilization, emotional regulation, social connection, and gradual reintegration into ordinary life. The theoretical framework therefore combines the biopsychosocial model of trauma, Bronfenbrenner's ecological theory, humanistic pedagogy, social-emotional learning, and trauma-sensitive pedagogy.

In this study, trauma-sensitive education is understood as a set of pedagogical, relational, organizational, and institutional practices designed to reduce the risk of retraumatization and to support children's recovery through safety, predictability, trust, emotional regulation, and coordinated adult care. It involves routines and rituals, calm communication, flexible assessment, recognition of trauma symptoms, cooperation with families and psychological services, and teacher preparation to act as a stable affective regulator without assuming the role of a clinical therapist.

Previous studies have emphasized the prevalence of PTSD symptoms among war-affected children, the relevance of CRIES-13 as a screening tool, and the effectiveness of trauma-focused psychotherapies such as TF-CBT (Alzaghoul et al., 2022; Bondaruk et al., 2020; Radstaak, 2020). However, access to specialized clinical care remains limited for many children, while schools are more widely available and can provide continuous everyday support. Ukrainian and international research has addressed psychosocial assistance, teacher support, and education in emergencies, but there remains a need to systematize education as a rehabilitative practice at the individual, classroom, institutional, and policy levels (Davydenko, 2022, Norwegian Refugee Council, 2023; Winthrop & Kirk, 2008).

The research problem that motivates this article is therefore how the educational environment can contribute to the rehabilitation of children with post-traumatic experiences caused by war, and under which pedagogical and institutional conditions this contribution becomes effective. The hypothesis is that a trauma-sensitive educational program can reduce post-traumatic symptoms and support the transition of some children from clinical to subclinical risk levels, especially when the program combines safety, social-emotional learning, teacher support, and cooperation with psychological services.

This theoretical and applied study combined qualitative source analysis with quantitative evaluation of a rehabilitation-oriented educational intervention. The theoretical stage consisted of a systematic review of Scopus, Web of Science, PubMed, and Google Scholar, using the keywords “war trauma children,” “trauma-informed education,” “psychosocial support in schools,” “social-emotional learning (SEL) in crisis,” and “teacher resilience.” Sources were selected when they addressed war-related trauma in children, school-based psychosocial support, trauma-sensitive or trauma-informed education, teacher roles in crisis contexts, or educational rehabilitation. International cases such as the Better Learning Programme, INTACT, and “Szkoła dostępna dla wszystkich,” as well as recommendations from UNICEF, UNESCO, WHO, and IASC, were analyzed in order to identify transferable principles for the Ukrainian context.

The empirical stage comprised a psychological and pedagogical experiment conducted from January to February 2026 in secondary schools with 30 children aged 7 to 12 who had been exposed to war-related traumatic experiences. The intervention was organized around a trauma-sensitive educational environment, including predictable routines, emotionally safe classroom interaction, social-emotional learning activities, grounding and stabilization exercises, art-based activities, cognitive support, teacher observation, and cooperation with families and psychological services. The objective was not to provide clinical psychotherapy, but to evaluate whether structured educational support could reduce post-traumatic symptoms and strengthen children’s sense of safety and self-regulation.

Post-traumatic symptoms were assessed before and after the program using the CRIES-13 scale, which measures intrusion, avoidance, and hyperarousal. Quantitative data were analyzed using descriptive statistics and Wilcoxon’s T-test (IBM SPSS 26.0), while qualitative observations were interpreted through thematic analysis. Triangulation was ensured by comparing scale results, teacher observations, and the theoretical principles derived from the literature.

The psychological and pedagogical experiment evaluated the dynamics of post-traumatic symptoms in 30 children aged 7–12 exposed to war-related traumatic experiences. Before the program (T1), the mean total CRIES-13 score was 38.7 (SD = 6.2), which is above the clinical threshold and indicates a high probability of PTSD symptoms. This initial result confirms that the group required structured support and that ordinary school routines alone would not be sufficient without trauma-sensitive adaptations. The highest mean score was observed for hyperarousal (15.1), followed by intrusion (14.2) and avoidance (9.4), suggesting that the children's main difficulties were related to physiological activation, intrusive recollections, anxiety, irritability, and concentration problems.

After the program (T2), the total mean score decreased to 29.2 (SD = 5.8), representing a reduction of 9.5 points ($p < 0.001$). This change moved the group mean below the clinical threshold and indicates that a predictable, emotionally safe, and supportive educational environment can contribute to symptom reduction. The largest decrease occurred in intrusion, which fell from 14.2 to 10.1 ($\Delta = -4.1$; $p < 0.001$). This result may be interpreted as evidence that the restoration of everyday safety, classroom routines, and supportive adult relationships helped reduce the frequency and intensity of unwanted memories and trauma-related thoughts.

Hyperarousal decreased from 15.1 to 11.3 ($\Delta = -3.8$; $p < 0.001$), indicating that the program also contributed to better emotional and physiological regulation. This result is consistent with the use of grounding exercises, calm teacher communication, predictable classroom structures, and social-emotional learning activities. Avoidance showed a smaller but statistically significant decrease, from 9.4 to 7.8 ($\Delta = -1.6$; $p = 0.002$). The slower change in avoidance is expected because avoidance often functions as a protective strategy: children may need more time, trust, and repeated experiences of safety before they can gradually reengage with people, places, and memories associated with traumatic events.

MATERIALS AND METHODS

This theoretical and applied study combined qualitative source analysis with quantitative evaluation of rehabilitation interventions. The theoretical stage involved a systematic review of Scopus, Web of Science, PubMed, and Google Scholar using keywords: “war trauma children,” “trauma-informed education,” “psychosocial support in schools,” “social-emotional learning (SEL) in crisis,” and “teacher resilience.” The theoretical basis included the biopsychosocial model of trauma, Bronfenbrenner's ecological theory, humanistic

pedagogy, and a trauma-sensitive approach. International cases (Better Learning Programme, INTACT, “Szkoła dostępna dla wszystkich”) and UNICEF, UNESCO, WHO recommendations were analyzed to adapt global developments to Ukraine. The empirical part comprised a psychological and pedagogical experiment (January–February 2026) in secondary schools with 30 war-traumatized children. The CRIES-13 scale assessed intrusion, avoidance, and hyperarousal pre- and post-program. Quantitative data were analyzed using descriptive statistics and Wilcoxon’s T-test (IBM SPSS 26.0); qualitative data underwent thematic analysis, ensuring triangulation and validity.

RESULTS

The distribution of children by clinical threshold provides a clearer view of the practical meaning of the intervention. At T1, 24 children (80%) scored above the clinical threshold, while only 6 children (20%) were at the subclinical level. At T2, the number of children above the clinical threshold decreased to 13 (43%), and 17 children (57%) were classified as subclinical. Thus, 11 children, corresponding to 37% of the sample, moved from the clinical to the subclinical group. This does not mean that all difficulties disappeared, but it indicates a clinically relevant improvement in the direction of stabilization and reduced PTSD risk.

A trauma-sensitive educational environment was evaluated in a psychological and pedagogical experiment involving 30 children (aged 7–12) who had been exposed to war and suffered from clinically significant PTSD. CRIES-13 scores at T2 (Wilcoxon T-test) for the total score: mean (SD) at T1 was 38.7 (6.2); intrusion was 14.2 (2.8), hyperarousal was 15.1 (2.9), avoidance was 9.4 (2.1). Significant pre- to post-program changes were found for all subscales with intrusion decreasing to 10.1 ($\Delta = -4.1$), the largest reduction ($p < 0.001$). This supports the idea that a safe, predictable, and supportive environment leads to fewer intrusions consistent with safety restoration as a core component of trauma recovery (Zasiekina et al., 2024).

Table 1.

Comparative analysis of post-traumatic stress scores on the CRIES-13 scale before and after the implementation of the rehabilitation and education program (n = 30)

Subscale	Before implementation (T1)	After implementation (T2)	Difference	Z	p
M (SD)	M (SD)	Δ			
Invasion	14.2 (2.8)	10.1 (2.4)	–	–4.1	<0.001
Avoidance	9.4 (2.1)	7.8 (1.9)	–1.6	–3.08	0.002
Hyperarousal	15.1 (2.9)	11.3 (2.6)	–3.8	–4.01	<0.001
Total score	38.7 (6.2)	29.2 (5.8)	–9.5	–4.27	<0.001

Note. The Authors. The level of significance was calculated using Wilcoxon's T-test.

The fact that 43% of the children remained above the clinical threshold after the program is equally important for interpretation. These cases show the limits of school-based rehabilitation when children have experienced severe trauma, such as loss of relatives, direct exposure to combat, witnessing violence, or absence of family support. For these children, trauma-sensitive education should be understood as the first level of support within a broader network that includes specialized psychotherapy, social services, and family assistance. Younger children (7–9 years) showed more expressive symptom remission, possibly because of greater psychological plasticity, while older children (10–12 years) showed slower progress, particularly in avoidance behaviors. This reinforces the need for differentiated, age-sensitive, and long-term interventions.

Hyperarousal fell from 15.1 to 11.3 ($\Delta = -3.8$; $p < 0.001$). Avoidance decreased from 9.4 to 7.8 ($\Delta = -1.6$; $p = 0.002$); this smaller change relates to its protective function, demanding safety and trust as well as a gradual widening of the child's world. A two-year program can start the process for change, but more time is required to completely overcome avoidance (Zasiekina et al., 2024). Total PTSD scores declined from 38.7 to 29.2 ($\Delta = -9.5$; $p < 0.001$), crossing the clinical cut-off of 30. Individual results were that fewer children scored above the cut-off from 80% (24) to 43% (13); 37% (11) fully dropped to subclinical levels, validating clinical significance. A score ≥ 30 is indicative of high risk for PTSD, and its trajectory is an important treatment outcome.

Table 2.

Distribution of children by level of post-traumatic stress before and after the implementation of the rehabilitation and educational program (n = 30)

Category	Stage T1 (before implementation)	Stage T2 (after implementation)	Dynamics			
	n	%	n	%	n	%
Exceeded the clinical threshold (>30 points)	24	80	13	43	-11	-37
Did not exceed the clinical threshold (≤30 points)	6	20	17	57	+11	+37
Decrease to subclinical level	—	—	—	—	11	37

Note. Developed by the authors based on the results of empirical research.

The results suggest that a trauma-sensitive educational environment can reduce PTSD symptoms in war-affected children and that its effectiveness depends on the articulation between pedagogical structure, emotional safety, and psychosocial support. The 37% reduction in the group above the clinical threshold is compatible with findings reported in school-based programs such as the Better Learning Programme, which has indicated 25–35% PTSD reduction, and with broader recommendations from UNICEF, UNESCO, WHO, and IASC concerning mental health and psychosocial support in emergency settings (Inter-Agency Standing Committee, 2007; Norwegian Refugee Council, 2023; Schultz & Norheim, 2015; Winthrop & Kirk, 2008).

The concept of trauma-sensitive education is central to understanding these findings. Its purpose is not to medicalize schooling or to transform teachers into psychotherapists. Instead, it proposes that teachers, school managers, psychologists, families, and community services should build an educational environment that avoids retraumatization and supports recovery through routine, safety, trust, relational stability, and opportunities for expression. In practice, this includes predictable schedules, clear and non-punitive rules, reduced exposure to unnecessary stressors, flexible assessment, attention to emotional triggers, collaborative work with families, and mechanisms for referral to specialized services when symptoms exceed what the school can address.

The data also show that educational interventions are especially relevant for mild-to-moderate PTSD symptoms and for the first stages of stabilization. Severe or complex PTSD requires combined support, including individual therapy, family work, and clinical follow-up (Alzaghoul et al., 2022). Therefore, the educational model proposed here should be interpreted

as complementary to specialized care. Its strength lies in continuity: while clinical services may be scarce, the school is present in children's daily lives and can provide repeated experiences of safety and belonging.

The model conceptualizes the education of war-affected children as a socioecological process in which recovery occurs through the interaction of individual, microsocial, and macrosystem levels. At the individual level, the focus is on screening, stabilization, emotional regulation, cognitive support, and expressive activities. At the microsocial level, the classroom, teacher, peers, and family form a relational environment that can either intensify trauma or support recovery. At the macrosystem level, educational policy, teacher training, supervision, anti-bullying programs, referral networks, and legal guidelines create the conditions for scaling up trauma-sensitive practices.

This model also implies a change in teachers' professional identity. Teachers remain educators, but in crisis contexts they also become key adults who can identify distress signals, regulate classroom climate, and sustain children's sense of safety. This expanded role requires institutional support, professional training, and supervision, because teachers themselves may experience secondary traumatization and burnout. Trauma-sensitive education therefore cannot depend only on individual teacher goodwill; it must be incorporated into school policy, teacher education, and national recovery strategies.

Planning education for children with PTSD also requires attention to delayed reactions and cognitive overload. Lessons may need to be slower, more visual, and more flexible; evaluation should avoid excessive pressure; and self-regulation practices such as breathing, movement, grounding, and the use of anchor objects can be incorporated into the school routine. The school may then operate as a "corridor of normality," offering routines and relationships that counterbalance the disorganization created by war.

The study showed that education can be a key component of rehabilitation for children who have experienced war, especially when the school environment is organized according to trauma-sensitive principles. The CRIES-13 total score decreased by 9.5 points ($p < 0.001$), and 37% of children moved from the clinical to the subclinical PTSD range. Improvements in intrusion and hyperarousal indicate that safety, predictability, social-emotional learning, teacher support, and structured routines can help restore emotional regulation and reduce trauma-related symptoms.

The theoretical contribution of the article lies in reconceptualizing school as a space of psychosocial rehabilitation operating at individual, microsocial, and macrosystem levels. The

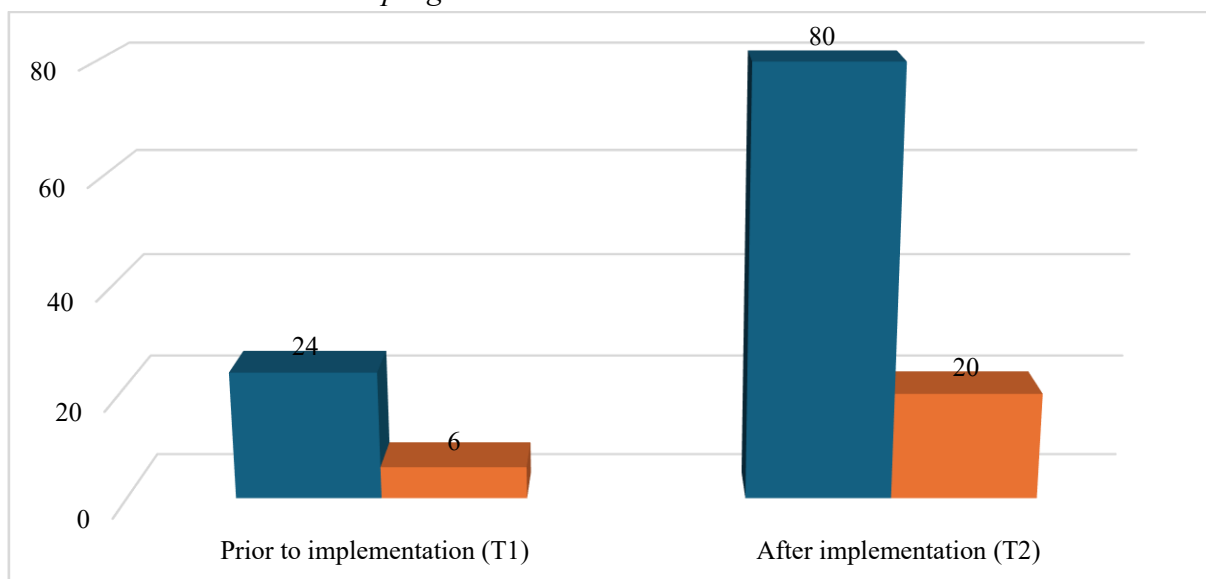
practical implication is that educational rehabilitation should include teacher training, classroom routines, flexible assessment, family cooperation, psychological screening, referral pathways, and institutional policies for trauma-sensitive schooling. In this sense, trauma-sensitive education is not an isolated technique, but a systemic approach to wartime and post-war recovery.

The study also has important limitations. The sample was small ($n = 30$), the intervention lasted only two months, there was no control group, and the assessment relied primarily on one screening instrument. The war context is still ongoing, which means that children's symptoms may change over time and that long-term effects cannot yet be fully measured. The findings should therefore be interpreted as preliminary and exploratory rather than as definitive evidence of effectiveness. Future research should include larger and more diverse samples, longitudinal designs, control or comparison groups, qualitative interviews with children, families, and teachers, and comparative analyses of programs such as BLP, INTACT, and domestic Ukrainian models.

Finally, trauma-sensitive education cannot substitute specialized psychotherapy for children with severe or complex PTSD. Its role is to provide the first and continuous layer of support through screening, stabilization, everyday safety, social integration, and referral to specialized services. When integrated with mental health care, family support, and public policy, schools can become compassionate and structured environments that help children rebuild trust, learning, and hope after traumatic experiences of war.

Figure 1.

Dynamics of the overall CRIES-13 indicator before and after the implementation of the rehabilitation and education program



Note. The Authors.

Absolute improvement in the dynamics of PTSD showed a reduction of 11 subjects (−37%) in the high-risk group and an increase of 11 participants (+37%) in the subclinical group and that implies that 37% of children moved from clinical to subclinical PTSD, which means mitigating the risks of developing chronic trauma and personality disorders (Zlivkov et al., 2023). This is in line with the Norwegian Refugee Council (2023), stating a 30–40% improvement through the Better Learning Programme; the 37% in this study lies within that margin.

Among children who showed positive dynamics, 43% still found themselves above the clinical cutoff, as they had experienced the most severe trauma (loss of a parent, direct combat, witnessing violence) or lacked familial support, emphasizing the importance of integrated educational/psychotherapeutic approaches (Alzaghouli, 2022). Symptom remission occurred in younger children (7–9 years) — owing to superior psychic plasticity, while adolescents (10–12 years) manifested subdued dynamics, particularly on avoidance behavior, aligning with stronger rigidity of adolescent coping mechanism and requirement for longer-term support.

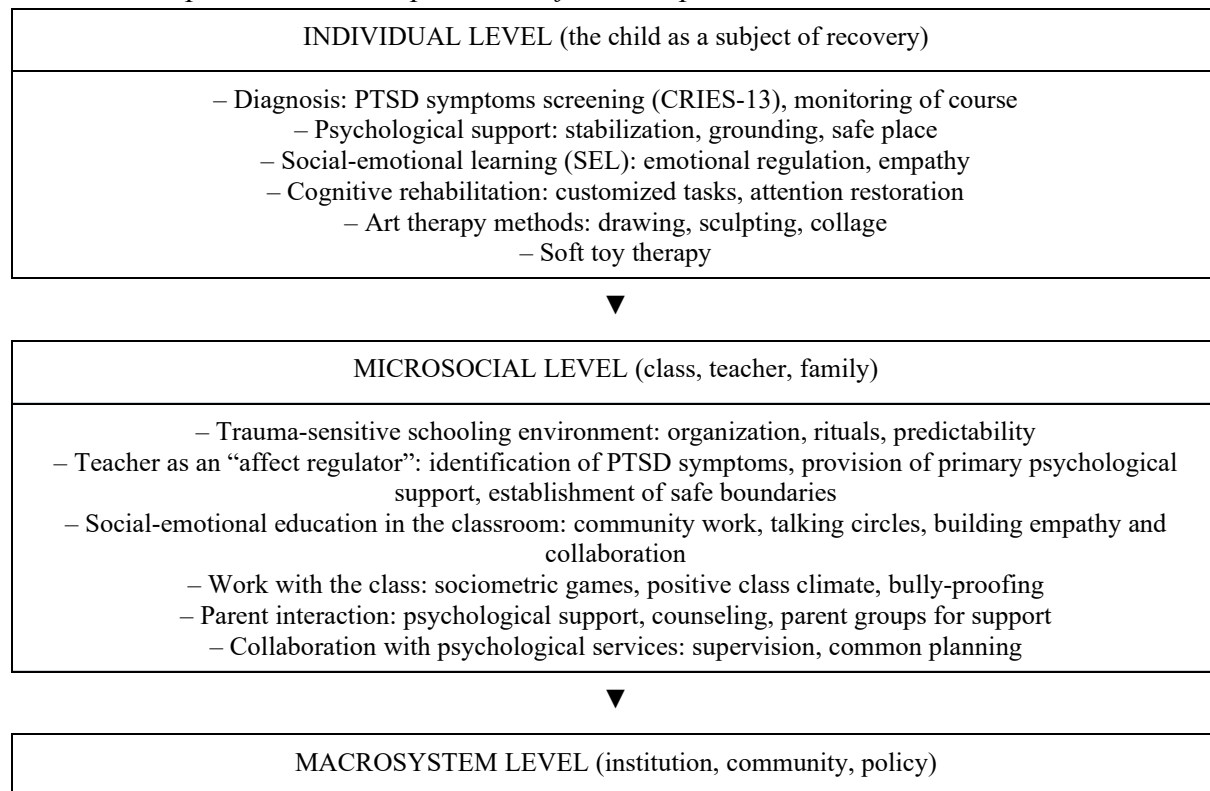
DISCUSSION

A trauma-sensitive educational environment reduced PTSD symptoms in war-affected children by 37% above the clinical threshold, aligning with UNICEF, UNESCO, and WHO

(Inter-Agency Standing Committee, 2007; Winthrop & Kirk, 2008). While TF-CBT and EMDR are gold-standard (APA, 2017) implemented in Ukraine (Bondaruk et al., 2020), <10% of children access such care. The Better Learning Programme (Norwegian Refugee Council, 2023) showed 25–35% PTSD reduction; this study's 37% aligns (Schultz & Norheim, 2015). Other models include INTACT (Terre des Hommes Hellas) and Poland's "School Open to All" (Ministry of National Education, 2023); Ukrainian methodologies include art therapy (Voznesenska & Sydorkina, 2016) and stuffed toy therapy (Naichuk & Skrypkinska, 2024). Educational interventions are effective for mild-to-moderate PTSD, but severe trauma requires combination with individual therapy (Posttraumatic Stress Disorder in Children..., 2024); both approaches are complementary (Ministry of National Education, 2023). Limitations: small sample (n=30), short duration, single tool, no control. Results support trauma-sensitive education in policy and training (Toronto Statement). The proposed model integrates individual, microsocial, and macrosystem levels (Denov et al., 2023).

Figure 2.

Structural and functional model of forms of work in the system of educational rehabilitation of children with post-traumatic experiences of the war period



- Institutional policy: trauma-informed school charter, anti-bullying programs, safety code of conduct
 - Teacher education: trauma-informed pedagogy training modules in preservice training
 - Supervisory support: prevention of secondary traumatization of teachers
- Inter-organizational collaboration: linkages to mental health centers, social services, and community organizations
- Scaling up practices: translating international models (BLP, INTACT, “Szkoła dostępna dla wszystkich”) in the Ukrainian context
- Regulatory and legal support: guidelines for trauma-sensitive education, resources for psychological support

Note. The Authors.

The model conceptualizes educating a child with special needs as a socioecological process in which daily living acts as the agent of change, further viewing the school as a comprehensive setting for education, care, support, and treatment. The model implicates a profound change in professional identity of teachers—early recognition of PTSD, provision of basic psychological support, establishment of a safe emotional environment—and calls for systemic teacher training and prevention of burnout. It distinguishes the dynamics of individual, microsocial (classroom, teacher, family), and macrosystem (policy) levels in transitioning from the school as knowledge transmission to the school as safety, care, and recovery.

Planning education for children with PTSD means paying attention to delayed reactions; the school is a “corridor of normality” lined with routines and predictable rules, once again functioning as a way to discover talent as a counter to trauma-driven narratives. Individual treatment is best. In light of cognitive impairments associated with PTSD, treatments need to be adapted on an individual basis: pace of material should be slowed, use visual aids, minimize cognitive overload, and teach self-regulation (breathing, movement, anchor objects). Calm, non-judgmental communication is necessary for home-school relations. Teaching should discard grades and external success as pressure causes retraumatization. The school’s job is to meet the child where they are, praise small progress, and move from holding them accountable to holding them up, establishing an environment where the child feels safe and appreciated.

FINAL CONSIDERATIONS

The research showed that education is a key element of rehabilitation for children who have experienced war, and that it offers them a sense of organisation and stability as well as social ties. CRIES-13 dropped 9.5 points ($p < 0.001$), and 37% moved out of the clinical PTSD range, improvements in intrusion and hyperarousal were strongly connected to regaining safety and self-regulation. The theoretical contribution reconceptualises school as a site of full-scale

rehabilitation on the individual, microsocial, and macrosystem levels, with practical implications for the teacher as “affect regulator.”

But the specialized education and clinical services cannot be a substitute for specialized psychotherapy for complex, severe PTSD; it is the primary continuum link (screening, stabilization, integration, consolidation) that needs to be woven among agencies. Prospective research should also address longitudinal and comparative model (BLP, INTACT, domestic models) analyses, effects of digital technology, and teacher secondary traumatisation. To summarize, trauma-informed education is a cost-effective way to invest in mental health and social capital, to reestablish safety and hope, with schools as compassionate guides in the journey to healing transgenerational trauma.

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APPENDIX

CHILDREN'S IMPACT OF EVENT SCALE (Children's Impact of Event Scale – CRIES-13)

(adapted into Ukrainian)

Instructions: Below are statements that describe different reactions children have to difficult or frightening events. Please read each statement carefully and indicate how often you have felt or thought this WAY OVER THE PAST 7 DAYS in relation to the event that concerns you most. Answer honestly. Your answers are confidential.

Response scale:

Points	Answer
0	Never
1	Rarely
3	Sometimes
5	Often

No	Statement	Never (0)	Rarely (1)	Sometimes (3)	Often (5)
1	Do you think about this event even when you don't want to?	☐	☐	☐	☐
2	Do you try not to think about this event?	☐	☐	☐	☐
3	Does it ever happen that you cannot remember what exactly happened?	☐	☐	☐	☐
4	Does this event put you in a bad mood?	☐	☐	☐	☐
5	Do you try not to talk about this event?	☐	☐	☐	☐
6	Do you ever think about this event for no particular reason?	☐	☐	☐	☐
7	Do you think this event did not actually happen?	☐	☐	☐	☐
8	Do you try to avoid things that remind you of this event?	☐	☐	☐	☐
9	Do you have images in your head about this event?	☐	☐	☐	☐
10	Do you feel scared or anxious because of this event?	☐	☐	☐	☐
11	Do you try not to feel emotions related to this event?	☐	☐	☐	☐
12	Do you ever get annoyed or angry about this event?	☐	☐	☐	☐
13	Do you have trouble falling asleep because of thoughts about this event?	☐	☐	☐	☐

KEY FOR PROCESSING RESULTS

Subscale	Points	Score range
Intrusion	1, 4, 6, 9	0
Avoidance	2, 5, 8, 11	0
Hyperarousal	10, 12, 13	0
Additional points (not included in the calculation)	3, 7	–

Calculating the score:

1. Add up the scores for each subscale separately.
2. Calculate **the total score** = sum of scores on all three subscales (Intrusion + Avoidance + Hyperarousal). Items 3 and 7 are NOT included in the total score.

Interpretation:

- **0–30 points** – subclinical level (low probability of PTSD). The child needs support, but the risk of disorder is low.
- **31–65 points** – clinical level (high probability of PTSD). An in-depth psychological examination and consultation with a specialist is recommended.

Additional markers:

- High scores on the **intrusion** scale indicate intrusive memories, nightmares, and repetitive thoughts.
- High scores on the **avoidance** scale indicate the child's attempts to avoid anything that reminds them of the trauma, emotional numbness.
- High scores on the **hyperarousal** scale reflect increased anxiety, irritability, sleep disturbances, and difficulty concentrating.

Source: Children and War Foundation. (2018). *Children's Impact of Event Scale (CRIES-13)*. <https://www.corc.uk.net/outcome-measures-guidance/directory-of-outcome-measures/child-revised-impact-of-events-scale-cries/>.

Individual post-traumatic stress scores on the CRIES-13 scale before (T1) and after (T2) the implementation of the rehabilitation and education program (n=30)

No	Intrusion T1	Avoidance T1	Hyperarousal T1	Total score T1	>30 T1	T2 intrusion	T2 avoidance	T2 hyperarousal	Total score T2	>30 T2	Δ total score
1	16	10	15	41	Yes	12	8	12	32	Yes	-9
2	14	9	16	39	Yes	10	7	11	28	No	-11

3	18	12	15	45	Yes	13	9	13	35	Yes	-10
4	12	7	14	33	Yes	9	6	10	25	No	-8
5	15	11	17	43	Yes	11	9	12	32	Yes	-11
6	13	8	15	36	Yes	9	7	11	27	No	-9
7	17	10	16	43	Yes	13	8	13	34	Yes	-9
8	11	9	14	34	Yes	8	7	10	25	No	-9
9	16	11	15	42	Yes	12	9	12	33	Yes	-9
10	14	8	16	38	Yes	10	7	12	29	No	-9
11	19	13	15	47	Yes	14	10	13	37	Yes	-10
12	13	9	14	36	Yes	9	8	10	27	No	-9
13	15	10	17	42	Yes	11	8	12	31	Yes	-11
14	12	7	13	32	Yes	8	6	9	23	No	-9
15	17	12	16	45	Yes	13	10	13	36	Yes	-9
16	14	9	15	38	Yes	10	7	11	28	No	-10
17	16	11	17	44	Yes	12	9	13	34	Yes	-10
18	11	8	14	3	Yes	8	6	10	24	No	-9
19	15	9	15	39	Yes	11	8	11	30	No*	-9
20	18	12	16	46	Yes	14	10	13	37	Yes	-9
21	13	8	14	35	Yes	9	7	10	26	No	-9
22	16	10	15	41	Yes	12	8	12	32	Yes	-9
23	12	7	13	32	Yes	9	6	9	24	No	-8
24	15	10	16	41	Yes	11	8	12	31	Yes	-10
25	10	6	12	28	No	7	5	9	21	No	-7
26	9	5	11	25	No	7	4	8	19	No	-6
27	11	7	13	31	Yes	8	6	10	24	No	-7
28	8	5	10	23	No	6	4	8	18	No	-5
29	10	6	12	28	No	7	5	9	21	No	-7
30	12	8	14	34	Yes	9	7	11	27	No	-7
M	14.2	9.4	15.1	38.7		10.1	7.8	11.3	29.2		-9.5
SD	2.8	2	2.9	6.2		2.4	1.9	2.6	5.8		1.6

Note. Participant No. 19 has a total score of 30 after the program, which is equal to the clinical threshold. Within the study, this case is classified as “does not exceed the clinical threshold.”

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